The Diocese of Santa Rosa

SECTION 125
HEALTH CARE BENEFITS PAYROLL DEDUCTIONS

Plan Year: July 1st, 2019 through June 30th, 2020

Enrollment in the Section 125 Plan of the Diocese of Santa Rosa allows eligible active employees to reduce their taxable income by withholding qualifying benefit premiums BEFORE taxes. When you begin employment in an eligible position you have the right to be enrolled in the Health Care Coverage offered by the Diocese of Santa Rosa effective the 1st of the month following or coinciding with your eligibility date.

EMPLOYEE INFORMATION

_____ _____ _____
Employee name SS# Date of birth

_____ _____
Email address Telephone #

_____ _____
Benefits eligible date Entity/Location name and city

AUTHORIZATION

☐ I elect and authorize payroll deduction for Health Care Coverage under the Section 125 Plan of the Diocese of Santa Rosa in the amount of $_____ per month / $_____ per pay period. Effective date: _____.

DECLINATION

☐ I elect not to participate in the "Health Care Coverage" for myself under the Section 125 Plan of the Diocese of Santa Rosa at this time. ***I am covered under my spouse's or my parent's health coverage***. I understand that I might receive compensation for declining this benefit.

☐ I elect not to participate in the "Dependent Health Care Coverage" under the Section 125 Plan of the Diocese of Santa Rosa at this time.

CONSENT

By signing below:

- I UNDERSTAND by signing and submitting this form I am making a binding election effective July 1st, 2019, and I cannot make any changes to my coverage until the beginning of the next plan year, July 1st 2020, "unless" I experience a qualifying life event (QLE). Prior to the first day of each plan year I will be offered the opportunity to change my benefit election for the following plan year. If I do not complete and return a new election form at that time, I will be treated as having elected to continue the same benefit coverage and rates in effect for the new plan year.

- I UNDERSTAND whether **electing** or **waiving my right to elect** the health package offered to me as of my eligibility date, I must complete the online enrollment process at www.RetaTrust.org within 30 days of my eligibility date noted above.

_____ _____
Participant Signature Date

For Location use only:

Date form Rec'd: _____ Info added to RetaTrust.org: _____ Deductions entered in IBS: _____

"If employee is waiving benefits, please provide a copy to the Diocesan Benefits Department"

Rev. 5/3/2019